PRINTED: 09/13/2011 FORM APPROVED OMB NO. 0938-0391

I AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A BUILO			
		09G219	B. WING		08/26/2011	
	ROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CO 615 55TH STREET, NE WASHINGTON, DC 20019	DE ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
	August 24, 2011 this sampling of three composition of five mintellectual disabilities conducted utilizing process.	rvey was conducted from rough August 26, 2011. A lients was selected from a lales with cognitive and es. This survey was the fundamental survey	W 00	Recewel 9 2 Department of H Health Regulation & Licenshi Intermediate Care Facili 899 North Capitol & Wisshington, D.C.	ealth g Administration ties Division st., N.E.	
W 159	observations and in and at two day prog client and administr incident and investigmental Retardation referred as Qualifie Professional (QIDP 483.430(a) QUALIF RETARDATION PRETARDATION PROTARDATION PRETARDATION PRETARDATION PROTARDATION PRO	IED MENTAL	W 15	W159 1. The staff involved has and re trained in this is mealtime protocol. The RC/RN will ensure that staff during mealtimes ensure that the mealting followed. 2. All staff were in service documentation and accollection. 3. The QDDP will ensure	ndividual's 9/21/11 the QDDP and the state they monitor the state at least 2x/week, to me protocol is being seed on IPP curate data	
	Based on observative review, the facility facilient's active treatm coordinated, integraqualified intellectual (QIDP), for three of (Clients #1, #2 and The findings include 1. Cross refer to With the findings included the content of the findings included the cross refer to With the cross refer to Wi	ated and monitored by the idisabilities professional three clients in the sample #3).		trained and are able to use of the elbow pads at The QDDP will ensure documents on a daily be of each of the adaptive used by the individuals. All staff were in serviced or equipment monitoring form All staff were in serviced or documentation. See attached in service reco	monitor the correct and the foot box. that the staff pasis the condition equipment being the daily adaptive the daily adaptive the daily adaptive	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 09G219

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE A. BUILDING				
		09G219	B. WIN	G		08/20	3/2011
	ROVIDER OR SUPPLIER			61	EET ADDRESS, CITY, STATE, ZIP COL 15 55TH STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	2. Cross refer to W to ensure program collected for Client 2. Cross refer to W to failed to ensure to devices was mainta and #2. 483.440(d)(1) PRO	/252. The facility's QIDP failed documentation was accurately	W 1	249			9/21/11
	formulated a client' each client must re treatment program interventions and s and frequency to se	s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program		Ir Ll at an	1&2.All staff were re train Mealtime Protocol and IF the future the QDDP and IF will ensure that staff are least a weekly basis during and there is documentation an ampleted.	PP. RC, RN and cobserved on mealtimes	
	Based on observa review, the facility's professional (QIDP received continuous the three clients inc #1 and #3) The findings included 1. On August 25, 2 the direct support so Client #3 his dinner assistance. One make the professional prof	is not met as evidenced by: tion, staff interview and record is qualified intellectual by failed to ensure clients is active treatment, for two of cluded in the sample. (Client e: 011, beginning at 6:36 p.m., staff was observed feeding in with hand over hand inute later, the direct support ent's spout cup in his mouth			See attached mealtime preservice record	otocol IPP –	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	09G219	B. WIN	G		08/2	26/2011
NAME OF PROVIDER OR SUPPLIER METRO HOMES, INC			615	T ADDRESS, CITY, STATE, ZIP CODE 55TH STREET, NE SHINGTON, DC 20019	.	
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
6:46 p.m., the direct the client his meal wassistance. At 6:55 spoon fed the client interview with the direct, 2011, at 7:05 p.r. think the client wants spoon. " Review of Client #3's dated April 24, 2011 approximately 10:45 hold his spoon and provided in the client wants spoon." Review of Client #3's (IPP) dated April 25, 11:00 a.m., revealed "Given hand over has feed himself with five 80% of trials for six 6 2012." Further revier following steps: a. The client will be whold his spoon; b. Staff will assist to gently prompt the client mouth;	and over hand assistance. At support staff began to feed ithout hand over hand p.m., the direct support staff his chocolate pudding. The ect support staff on August m., revealed she "did not led to hold his built up handle as occupational assessment on August 26, 2011, at a.m., revealed the client will participate with assistance. Is individual program plan 2011 on August 26, 2011, at an objective that stated, and assistance, [the client] will be spoons during meals on consecutive months by April lev of the IPP revealed the verbally prompted by staff to scoop food on spoon and lent to bring food to his ge and reinforce the client	W	249			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G219	B. WIN	G		08/2	26/2011
	ROVIDER OR SUPPLIER			615 5	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET, NE HINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 249	Interview with the 0 approximately 10:3 retrain the staff on	QIDP on August 26, 2011 at 80 a.m., revealed she will	W 2	49			
	implemented Clien 2. On August 25, 3 Client #1 was obse 6:42 p.m., the clien manager placed th client then began to house manager ge his left hand as the hand. At 6:44 p.m. client to slow down himself at a slower 6:52 p.m., the house client the rest of his	t #3's IPP as recommended. 2011, beginning at 6:38 p.m., erved eating at a fast pace. At at drank water as the house e spout cup to his mouth. The control of the control					
	day at 7:00 p.m., re	nouse manager on the same evealed the client eats fast and his food to get everywhere".		:			
	dated November 4	i's occupational assessment, 2010 on August 26, 2011, at it the client eats fast and needs to slow down.		:			
	review of Client #1' 2010, revealed an verbal prompts, [th during meals on 80 months by Novemb	at approximately 9:30 a.m., s IPP dated November 1, objective that stated, "Given e client] will eat at a slow pace 9% of trials for six consecutive per 2011". Further reviewing feeding techniques:					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		09G219	B. WING		08/2	26/2011	
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO 615 55TH STREET, NE WASHINGTON, DC 20019	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 249	Continued From pa	ge 4	W 24	9			
	a. Monitor for rapid	eating pace;					
	prompts such as ha	ompts and if necessary tactile and over hand assistance to the table between each bite of					
	c. Shake off excess placing in his mouth	s food from the spoon before				;	
W 252	•	ence that the facility #1's IPP as recommended. GRAM DOCUMENTATION	W 25	2			
	specified in client in	omplishment of the criteria dividual program plan documented in measurable		1&2.All staff were re trained on Protocol and IPP.	Mealtime	9/21/11	
	Based on staff inte facility failed to ensu	s not met as evidenced by: rview and record review, the ure program documentation ected, for one of the three lient #3)	ens bas and	the future the QDDP and RC, RN sure that staff are observed on at less during mealtimes and there is did teaching completed. See attached mealtime protocol I ord	east a weekly locumentation		
	The findings include	9 :	,				
	26, 2011, at 11:30 a Individual Program 2011, required the othe number of times feed himself with as collection sheet rev	249). Record review on August a.m., revealed Client #3's Plan (IPP) dated April 25, direct care staff to document as the client was able to spoon asistance. Review of the data ealed the direct care staff over hand assistance from					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G219	B. WING		08/26	3/2011
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/20	
•	IOMES, INC			815 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
W 252	times Client #3 spo	st 2011. o document the number of	W 252	W356 Mr. Lawton had a dental cons		9/21/11
W 356	assistance. 483.460(g)(2) COM TREATMENT	IPREHENSIVE DENTAL	W 356	4/09 – deep scaling completed 9/09 – adult prophylaxis with completed		
	treatment services needed for relief of	isure comprehensive dental that include dental care pain and infections, , and maintenance of dental	·	12/09 – full mouth scaling co. 6/10 – examined for scaling – authorization 1/11 – full mouth gross debrid and prophylaxis completed. 8/11 – full mouth gross debrid	dement	
,	Based on interview facility failed to ens maintenance denta clients in the sample			The QDDP has a tooth brushi program and all staff have be serviced on it.	ng en in	
	on August 26, 2011 Client #1 had a der The LPN indicated, thirteen month interwas recommended the time the scaling the LPN, the client June 2010, however office in December appointment date finformed that the a	censed practical nurse (LPN) I, at 12:35 p.m., revealed Intal scaling on August 2, 1011. Inhowever, that there was a I to have the dental scaling and I was performed. According to I had the dental assessment in I when she called the dental		In the future the QDDP and R ensure that staff are observed implementing the tooth brush and document the same. The Director of Nursing has d a dental appt. tracking form to that such a delay does not occ In the future the RN Supervise ensure that monthly tracking i completed. See attached – in service recort ooth brushing IPP and dental with summary and dental apprentices.	leveloped of ensure sur again. or will is ard on consults	
	Record review on A	August 26, 2011, beginning at		tracking record	•	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G219	B. WING	•	08/26/20	011
	ROVIDER OR SUPPLIER		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 55TH STREET, NE ASHINGTON, DC 20019		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE CO	(X5) IMPLETION DATE
	concerning Client a services: a. June 21, 2010 - generalized bleeding uncooperative. Do therefore was unall Needs scaling. With authorization and cafter authorization b. August 2, 2011 the heavy tartar, heavy mouth gross debries referred for a dentain brushing teeth a heaving teeth and the time of the stata Client #1 had a services for the made as about the hearing and other devices interdisciplinary teas. This STANDARD Based on observative, the facility recommended asservices:	d the following information th's professional dental Perio-probing revealed ng. Non-verbal patient, very les not follow commands, let to take a Panorex x-ray. It submit request for leal to schedule appointment is received. (13 months later) - Oral exam; let plaque, heavy bleeding. Full dement and prophylaxis. Client let x-ray. Please assist patient to 2-3 times daily. Survey, there was no evidence received timely treatment laintenance of his dental health. ICE AND EQUIPMENT Traish, maintain in good repair, of use and to make informed use of dentures, eyeglasses, communications aids, braces,	W 436	W436 1. The QDDP will ensure that and are able to monitor the concelbow pads and the foot box. The ensure that the staff document of the condition of each adaptive being used by the individuals. 2. The foot box has been replace have been in serviced on the acception of the equipment policy and procedure tracking form See attached in service recorded adaptive equipment monitoring	rect use of the The QDDP will on a daily basis equipment ced and staff daptive re and the daily on daily	9/21/11
	sample. (Clients #	i and #2)			1	

Event ID: JCEV11

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G219	B. WING		08/2	26/2011	
	ROVIDER OR SUPPLIER		615	ET ADDRESS, CITY, STATE, ZIP CODE 55TH STREET, NE ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 436	Continued From pa	ge 7	W 436				
	The findings include	e:				·	
	arm pads were mai evidenced below: On August 25, 201 scar was observed he sat in the recline 11:00 a.m., on the cobserved wearing a on his left arm, about Interview with the Country of the same day, at 4: incident investigation of the same day, at 4: incident investigation of the floor and injured walking in the living walking in the living the same day, at 4: incident investigation of the floor and injured walking in the living walking in the living	dualified Intellectual fessional (QIDP) on August m., revealed that on July sustained the aforementioned by when he fell while ving room. The QIDP indicated recommended to wear elbow steady gait. According to the elbow pads had a tendency not have been on the client's ay program staff on August a.m., revealed that the client's ely, and that it was necessary requently to ensure that they					

•	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	
		09G219	B. WING		08/	26/2011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 436	white wearing elbor On August 26, 201 the QIDP presente she stated were pu Client #1 on Augus survey, however, th Client #1's elbow p maintained in good prescribed.	mbulate using his gait belt, w and knee pads as tolerated. 1, at approximately 4:00 p.m., d a pair of elbow pads, which irchased as a replacement for st 25, 2011. At the time of the ne facility failed to ensure that ads were consistently I repair to be worn as	W 436			
	support staff wheel room. The client's to over two pillows the other in his foot bot another direct supphis bedroom to chat the direct support sinto the living room the client's feet were	led Client #2 into the living legs were observed hanging at were stacked on top of each at approximately 5:20 p.m., fort staff wheeled the client to lange his clothes. At 5:48 p.m., staff wheeled Client #2 back are placed on one pillow and the laced vertically behind his legs		,		
	review of Client #2' dated July 1, 2011, ensure that the clie should use two sm support his lower e foot box needs to be the PT note revealed.	1, at approximately 10:00 a.m., s physical therapy (PT) note revealed that staff must ent is properly position. Staff all pillows in the foot box to extremity because the current be adjusted. Further review of ed that staff was trained on the positioning of Client #2's	and the second s			
		ualified intellectual fessional (QIDP) on August 26, , revealed that the wheelchair				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		09G219	B. WIN	€G	,	08/2	26/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	box. Further intervie contact the vendor	ge 9 for a part for the client's foot ew revealed that she tried to minutes before the interview, day the footbox will be	W	436			
	The facility failed to Client #2's footbox physical therapist.	ensure timely adjustments in as recommended by the		:			
			•				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		COMPLI	(X3) DATE SURVEY COMPLETED 08/26/2011	
AME OF PROVIDER OR SUPPLIE		615 55TH	DRESS, CITY, STREET, NOTON, DC 2		1 00/2	WEUII	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLE DATE	
24, 2011 through three residents we five males with condisabilities. This the fundamental observations and at two day proceedings of the observations and at two day proceeding and at two day proceeding and at two day proceeding and at two day proceedings of the incident and investmental Retardation referred as Quality Professional (QIII) 1090 3504.1 HOUSEK The interior and communitations of odors. This Statute is maked on observing on the proceedings of the province of the	vey was conducted from August 26, 2011. A sizes selected from a popognitive and intellectual survey was conducted survey process. The survey were based of interviews with staff interviews with staff interprocess, as well as a mainistrative records, inconstigation reports. [Quadra Professional(QMRP fied Intellectual Disabil DP) within this report.	ampling of pulation of all utilizing on the home eview of luding alified by will be ities. P shall be ractive, ctionable y: w, the I ne facility's nealth and		 All additional ada being utilized by t put away in storag The toilet set has t The living room set 	been replaced. ofa has been replaced. esser drawer has been round the exterior een replaced. nd RC will ensure that lits are completed so		
manager, (HM) o	interview with the facili n August 25, 2011, be ed the following deficie	ginning at				: ! !	

Health Regulation & Licensing Administration

STATE FORM

Health Regulation & Licensing Administration									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
	09G219				08/26/2011				
NAME OF PROVIDER OR SUPPLIER	j	STREET ADD	DRESS, CITY,	STATE, ZIP CODE	•				
METRO HOMES, INC			STREET, N TON, DC 2		-				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL :	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE				
the vent in the entr	ing and peeling paint ance hall celling.		1090						
that was not being room there were so a. Bathroom #1 had 4. In the living room leather on the head 5. In Resident #5's would not close process. There was a rott exterior window sill	bedroom, the dresse	nt storage I chairs. t. ad torn er drawer an eated on		1. The QDDP will ensure that st and are able to monitor the corre elbow pads and the foot box. The ensure that the staff documents to feach adaptive equipment bein individuals, on a daily basis. 2. The foot box has been replace have been in serviced on the adaequipment policy and procedure tracking form 3. All staff were re trained on Me Protocol and IPP. 4. All staff were in serviced on I documentation and accurate dataeprocessors.	ect use of the le QDDP will the condition le used by the le dand staff le and the daily le lime				
needs of the reside Habilitation plans. This Statute is not Based on observat review, the group hintellectual disabilit that each resident's was coordinated, in Qualified Intellectual	f provide adequate port to efficiently meet as required by the met as evidenced by ion, interview, and recome for persons with les (GHPID) failed to a active treatment provide Disabilities Professissidents in the sample and #3).	eir cord ensure gram ed by the ional	I 180	In the future the QDDP and the ensure that they monitor the star mealtimes at least 2x/week, to e mealtime protocol is being followstaff document the program data. In the future the QDDP and RC, RN ensure that staff are observed on at least starting mealtimes and there is and teaching completed. See attached mealtime protocol record, record on daily adaptive equimonitoring, and IPP documentation	ff during ensure that the lowed and that a accurately. I and LPN will least a weekly documentation IPP — inservice sipment				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A BUILDING B. WING 09G219 08/26/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1180 1 180 Continued From page 2 1. Cross refer to federal deficiency report citation - W436.1 The facility's QIDP failed to coordinate services to ensure Resident #1's elbow pads were maintained in good repair. 2. Cross refer to federal deficiency report citation - W436.2 The facility's QIDP failed to coordinate services to ensure Resident #2's wheelchair footbox was maintained in good repair. 3. Cross refer to W249. The facility's QIDP failed to ensure Residents #1 and #3 received continuous active treatment. 4. Cross refer to W252. The facility's QIDP failed to ensure program documentation was accurately collected for Resident #3. 1401 3520.3 PROFESSION SERVICES: GENERAL 1401 **PROVISIONS** Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident for one of three residents in the sample. (Resident #1)

Health F	Regulation & Licensir	ng Administration						
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 1990219		(X2) MULT A. BUILDIN B. WING	FEE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/26/2011		
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
METRO HOMES INC			H STREET, NE GTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
i 401	Continued From pa	age 3		I 401				
	The finding include	s:						
	The facility failed to ensure preventive care for the maintenance dental health, for Resident #1. Interview with the licensed practical nurse (LPN) on August 26, 2011, at 12:35 p.m., revealed Resident #1 had a dental scaling on August 2, 1011. The LPN indicated, however, that there was a thirteen month interval between the time the resident was recommended to have the dental scaling and the time the scaling was performed. According to the LPN, the resident had the dental assessment in June 2010, however when she called the dental office in December 2010 to obtain an appointment date for the scaling, she was informed that the authorization for the scaling had not been received from the funding agency. Record review on August 26, 2011, beginning at 1:45 p.m., revealed the following information concerning Resident #1's professional dental services: a. June 21, 2010 - Perio-probing revealed generalized bleeding. Non-verbal patient, very uncooperative. Does not follow commands, therefore was unable to take a Panorex x-ray. Needs scaling. Will submit request for authorization and call to schedule appointment after authorization is received.			wton had a dental consult in: 4/09 — deep scaling completed 9/09 — adult prophylaxis with polishing completed 12/09 — full mouth scaling completed 6/10 — examined for scaling — authorization 1/11 — full mouth gross debridement and prophylaxis completed. 8/11 — full mouth gross debridement completed. The QDDP has a toothbrushing program and all staff have been in serviced on it. In the future the QDDP and RN will ensure that staff are observed implementing the toothbrushing IPP and document the same. The Director of Nursing has developed a dental appt. tracking form to ensure that such a delay does not occur again. In the future the RN Supervisor will ensure that monthly tracking is completed. See attached — in service record on tooth brushing IPP and dental consults with summary and dental appt. tracking form			9/20/11	
	mouth gross debrid Resident referred for	plaque, heavy bleed iement and prophyla: or a dental x-ray. Ple teeth at 2-3 times da	xis. ase assist	S	ининагу ано сента аррг. ггаски 	ring form		

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 08/26/2011 09G219 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1401 1401 Continued From page 4 At the time of the survey, there was no evidence that Resident #1 had received timely treatment services for the maintenance of his dental health. 1422 1422 3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training 9/21/11 The staff have been disciplined and re trained in and assistance to residents in accordance with both the individual's mealtime protocols. the resident 's Individual Habilitation Plan. In the future the QDDP and the RC/RN will ensure This Statute is not met as evidenced by: that they monitor the staff during mealtimes at least Based on observation, staff interview and record 2x/week, to ensure that the mealtime protocol is verification, the facility's staff failed to ensure that being followed. residents' training objectives were implemented in accordance with their Individual Support Plan See attached mealtime and IPP in service record (ISP), for two of the three residents in the sample. (Resident #1 and #3) The findings include: 1. On August 25, 2011, beginning at 6:36 p.m., the direct support staff was observed feeding Resident #3 his dinner with hand over hand assistance. One minute later, the direct support staff placed the resident's spout cup in his mouth without the use of hand over hand assistance. At 6:46 p.m., the direct support staff began to feed the resident his meal without hand over hand assistance. At 6:55 p.m., the direct support staff spoon fed the resident his chocolate pudding. Interview with the direct support staff on August 25, 2011, at 7:05 p.m., revealed she "did not think the resident wanted to hold his built up handle spoon. " Review of Resident #3's occupational assessment dated April 24, 2011 on August 26, 2011, at approximately 10:45 a.m., revealed the

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G219 08/26/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1422 1422 Continued From page 5 resident will hold his spoon and participate with assistance. Review of Resident #3's individual program plan (IPP) dated April 25, 2011 on August 26, 2011, at 11:00 a.m., revealed an objective that stated, "Given hand over hand assistance, [the resident] will feed himself with five spoons during meals on 80% of trials for six consecutive months by April 2012." Further review of the IPP revealed the following steps: a. The resident will be verbally prompted by staff to hold his spoon; b. Staff will assist to scoop food on spoon and gently prompt the resident to bring food to his mouth: c. Staff will encourage and reinforce the resident when he completes directives; d. Staff will allow the resident to perform as his level permits and document the number of times; Interview with the QIDP on August 26, 2011 at approximately 10:30 a.m., revealed she will retrain the staff on Resident #3's IPP. There was no evidence that the facility implemented Resident #3's IPP as recommended. 2. On August 25, 2011, beginning at 6:38 p.m., Resident #1 was observed eating at a fast pace. At 6:42 p.m., the resident drank water as the house manager placed the spout cup to his mouth. The resident then began to eat at a fast pace again. The house manager gently placed her hand on top of his left hand as the resident

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1 422	house manager as The resident then be slower pace with we the house manage the rest of his dinner manager spoon feet pudding. Interview with the heart of the day at 7:00 p.m., reand she "did not we everywhere". Review of Resident assessment dated 26, 2011, at 9:20 at fast and needs professed and review of Resident 2010, revealed and verbal prompts, [the pace during meals consecutive months review revealed the a. Monitor for rapid b. Provide verbal prompts such as he place his spoon on food;	ht hand. At 6:44 p.m. ked the resident to sibegan to feed himselferbal prompting. At 6 repeat to feed the resident his chore. At 6:54 p.m., the left the resident his chore. At 6:54 p.m., the left the resident his chore. At 6:54 p.m., the left the resident his chore. At 6:54 p.m., the left the resident his food to get at 1's occupational November 4, 2010 o.m., revealed the resident his from staff to slow at approximately 9:30 for the staff to slow at approximately 9:30 for significant his form staff to slow at approximately 9:30 for following feeding terms and if necessing pace; rompts and if necessing pace; rompts and if necessing pace; food from the spool staff to slow at the table between each staff to slow at the table between each staff to slow at the spool staff the	ow down. f at a :52 p.m., esident house colate e same eats fast n August ident eats w down.) a.m., mber 1, "Given a slow ix ". Further chniques: ary tactile ance to ach bite of	1 422			
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